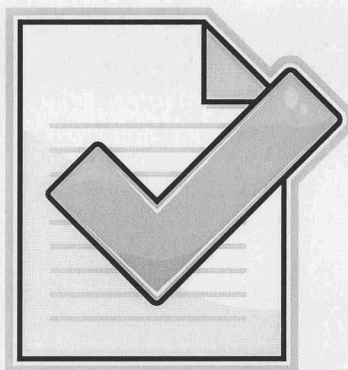


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**Assessing Health Education Practice
in
Policy and Built Environment Initiatives**



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SC DHEC Region 1**

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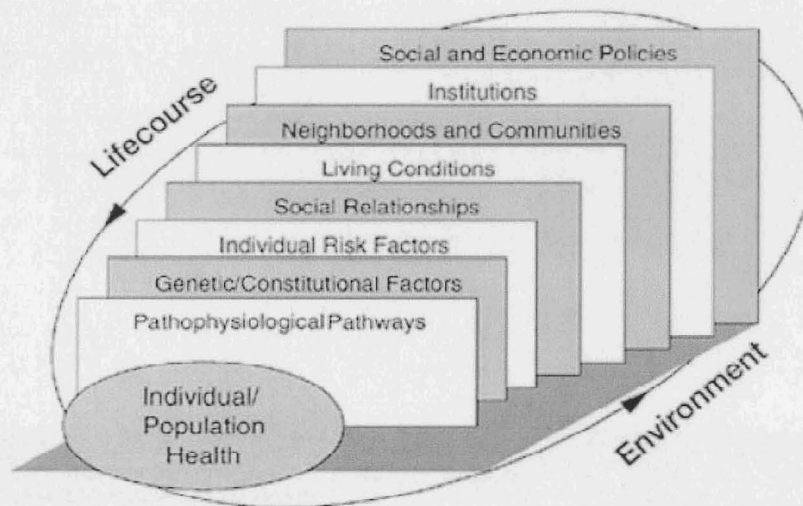
STATE DOCUMENTS

Project Purpose:

The purpose of this CPM project is to develop a policy and built environment assessment tool that can be included in the Health Education Practice Manual as an option for quality assurance of professional practice.

Problem Statement:

A new focus of Health Education practice at the local, state, and national level is to advocate for and facilitate formal policy change to support individual behavior change. This approach is a critical component of the socio-ecological model of behavior change (see figure below).

Socio-Ecological Model of Health

Reference: IOM (Institute of Medicine). 2000. Promoting Health: Intervention Strategies from Social and Behavioral Research, p. 43. Washington, DC: National Academy Press.

The Centers for Disease Control and Prevention (CDC) convened a group of experts in health promotion in March of 2006 to discuss the future role and direction for the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). One recommendation in their published report was that the NCCDPHP promote training

and capacity building to implement the socioecological approach including training in advocacy and policy work.

A Health Educator's individual knowledge and skill plays an important role in the success of policy change efforts. There is a need to provide practice feedback to Health Educators regarding their competencies in policy and built environment change processes. DHEC Region Directors of Health Education do not have a tool to assess health education practice in policy and built environment change strategies. We need a tool that provides a comprehensive assessment of policy change competencies to document the level of skill and application of best practice by the employee. The tool would provide a means of giving feedback to health education staff to improve their policy skills.

Both the DHEC Health Services Work Force Continuity and Development Plan and the Region 1 Work Force Continuity and Development Plan mention the need to develop and send staff for Core Public Health Training. One of the six proposed courses is Policy and Advocacy. This course has not been developed yet due to lack of funding.

The Office of Public Health Education Strategic Plan includes ensuring that Continuous Quality Improvement (CQI) procedures are in place and that processes exist for assessment of staff development and training needs. The tool will help identify areas for improvement via coaching, training or other methods and can be used by supervisors to develop the short-term training plan in the Employee Performance and Development Plan (EPDP) Part III. Future Training and Development section. Additionally, this project helps support the national movement in public health to improve workforce skills in policy work.

Data Collection:

A review of the literature revealed few documents related to competencies in public health policy and built environment change and assessment of those competencies. Competencies are defined as the ability to perform according to a pre-defined standard. Policies are defined as laws, regulations, and rules; both formal and informal. The built environment is defined as the physical man made environment such as trails, parks, sidewalks, stairway access, and other structures. Competencies used in changing policies and the built environment are the same.

PubMed was used in the search and no related articles were discovered. The assistance of the medical librarians in DHEC's Electronic Library Services and Assistance (ELSA) office was requested and they were unable to locate journal articles on this topic. Internet searches yielded two publications on policy competencies published by the Directors of Health Promotion and Education (DHPE) and one related article about measuring competencies of health care providers.

Data Analysis:

Nationally, CDC provided funding to DHPE to develop a list of competencies for policy work in public health. DHPE published Public Health Solutions Through Changes in Policies, Systems, and the Built Environment: Specialized Competencies for the Public Health Workforce in 2006. This effort was based on earlier work by DHPE (formerly ASTDHPPE) published in 2001, Policy and Environmental Change: New Directions for Public Health.

Also in 2001, The Council on Linkages Between Academia and Public Health Practice developed Core Competencies for Public Health Professionals based on the 10

Essential Services for Public Health. Essential Service #5: *Develop policies and plans that support individual and community health efforts* relates directly to this project.

DHPE's HPEC list was developed from the Core Public Health Competencies and in-depth interviews with health promotion stakeholders and practitioners at the federal, state, and local level. Once published, DHPE sought additional funding from CDC to develop a comprehensive curriculum to teach policy skills based on these competencies. James Emery, MPH, and Carolyn Crump, PhD with the UNC Chapel Hill School of Public Health are the consultants leading this project. They formed an advisory committee to guide curriculum development and I have been an active member of that committee since its formation in 2007.

South Carolina has been fortunate to have hosted the pilot of the first of 5 modules in the curriculum series in our state. The full 2 day version was piloted in March 2008 and a "light" half-day version was piloted at the SC Public Health Association conference in May 2008. Evaluations from both pilots revealed a desire and need for more skill building for public health practitioners doing policy work. We hope to pilot additional modules in the state as Mr. Emery and Dr. Crump develop them.

One article was located that provided some information on measuring competencies. Measuring the Competence of Healthcare Providers focuses on measurement of health care skills, primarily of nurses. It does a good job of explaining how competencies are acquired, the purpose of measurement to assure for quality practice, and assessment methods. Most methods discussed in the article work best with competencies that can be directly observed such as procedures or treatments. The competencies for policy work would be difficult to observe directly. The method most

related to this project is the performance appraisal because it assesses multiple competencies. This method is subjective and the quality of the assessment will depend on the skill of the reviewer. However, the article adds that use of multiple sources for the appraisal can reduce the subjective nature of the assessment.

A subset of a performance appraisal could include a post intervention debriefing. A debriefing would provide a vehicle for structured feedback that staff need to improve the next policy intervention. A debriefing checklist could also be used by a health educator as a self-assessment as they are going through a policy process; reviewing the competencies as checkpoints to assure key steps are not missed.

No policy practice assessment tool was located via a literature review or discussion with professional contacts so a tool was developed for this project.

Implementation Plan:

Development of the tool did not require significant cost or resources other than staff time. The key stakeholders included the front line Health Education staff and their supervisors who were involved throughout the process. The key steps in developing and piloting the tool were:

August	Review of the literature Develop draft tool Consultation with the Office of Performance Management
September	Preliminary feedback from front line staff Critique by the Region Directors of Health Education Critique by James Emery and Carolyn Crump
November	Pilot the tool with front line Health Education staff Revise the tool based on the pilot
December	Include the tool in the next revision of the Health Education Practice Manual as an option for quality assurance

Key challenges to use of the tool include lack of knowledge of policy work by supervisors, limited number of policy or built environment initiatives by front line staff,

the long-term nature of the initiatives (often several years), and time needed by supervisors to use the tool to give staff feedback. The Region Health Education Directors are committed to advocating for training in policy and built environment. The annual Health Education conference in 2007 focused on policy skills. As we build these skills we expect to see additional policy work completed by local staff. In addition, the chronic disease programs are increasingly requiring policy and built environment change as deliverables in our federal contracts. Thus we must increase our efforts in this area. Lastly, the agency added a performance measure on quality assurance (QA) in our discipline in 2006. This new tool provides another option to meet this performance measure.

A draft tool was developed based on the HPEC competencies. The stakeholders were emailed drafts of the tool and interviewed to gather input on design and potential use of the tool prior to piloting the tool.

The Quality Improvement Coordinator in the Office of Performance Management, DHEC Health Services was contacted first. He suggested changing the rating scale from using met/unmet to assess whether a competency was used in the policy process and replacing it with a Likert scale to assess skill level of the practitioner. He also suggested developing an example of each competency to help orient staff and supervisors to the meaning of the competencies.

The tool was modified to rate skill level as novice, advanced beginner, competent, proficient, and expert. Region 1's front line staff reviewed and commented on the second draft. They preferred a rating of met, unmet, and not applicable rather than the skill level rating. They also commented they would use the tool to guide them in their policy work.

The tool was then modified to include both assessments. The met/unmet rating will apply to the total process including efforts by policy change team members. The skill level rating will apply to the individual health educator being reviewed.

The third draft was emailed to Region Directors of Health Education and discussed at the state meeting in September. A second document including standards for each competency was also emailed. The Directors wanted inclusion of both rating scales in the tool. They also suggested some clarification and explanation of language in a few standards.

The third draft was also emailed to Jim Emery and Dr. Crump. They suggested some minor language changes in the competencies themselves and stated the competencies may be revised in a year or so to improve resonance with practitioners.

The fourth draft was piloted with front-line health educators in Regions 1 and 5. Three recently hired health education staff in Region 1 reviewed the tool and were interviewed to assess their comprehension of the competencies and standards. Competency 2.5 on decision analysis gave them the most problem. Examples of decision matrices were added to the standard. A community health work group in Region 5 completed the tool as a group process led by the Region 5 Director of Health Education. The group found no problems with the tool itself but did comment that after completing the tool they recognized that they need training on policy change processes.

During revisions of the tool, key criteria discussed were validity, reliability, and feasibility. Content validity concerns the degree to which a tool measures the intended content area. This is determined by expert judgment. DHPE has assured the content validity of the competencies. Also important is predictive validity, which is the degree to

which the tool can predict future performance, i.e., success with policy interventions. Predictive validity cannot be determined until the tool has been in use for some time. An adequate number of tools will take time to collect because of the limited policy change work being done at this time and the fact that these initiatives can span several years. Supervisors may need a year or more to compare current/actual ratings on a policy initiative against future/predicted performance in policy work.

Reliability is the consistency of rating between raters. The skill level rating is subjective based on the experience and content knowledge of the rater. Reliability was addressed by developing standards for each competency and by discussing rating with the Region Directors of Health Education who are most likely to use the tool. Raters also have access to policy reference materials developed by DHPE.

Feasibility involves whether the will and resources exist to implement use of the tool. This will vary from region to region based on the level of policy work being performed and comfort level of the supervisors in doing this assessment. However, the Region Directors of Health Education are in agreement that we need to proceed with development and use of this tool.

Evaluation Method:

The short-term formative evaluation for this project involved modifying drafts of the tool based on feedback by stakeholders collected via individual interviews and group discussions. Additionally, the tool was piloted and modified based on the results of that pilot as discussed in the section on the implementation plan.

Long-term evaluation will involve periodic feedback from stakeholders, which will trigger future revisions. We expect the first revision will be made based on

qualitative feedback from Directors of Health Education after the tool has been in use for one year. The tool will be placed in a supplemental section of the Health Education Practice Manual until the next formal revision of the manual due in 2013. The Office of Public Health Education assures that the manual is reviewed and revised every 5 years. Thus the tool would be formally reviewed at least every 5 years.

In addition, the agency's performance indicator 5A.2q, *Percent of classified Health Education staff that receive at least one supervisory quality assurance (QA) review using a QA tool from the Health Education Manual* is reported on annually by the Region Directors of Health Education. Though we are not required to state which QA tools were used to meet the requirement, the Office of Public Health Education can collect that information.

Summary and Recommendations:

The QA review tool developed for this project fills a critical need in providing practice feedback to staff doing policy work. Inclusion of the tool in the Health Education Practice Manual has been approved and the tool will be available as a supplement to the manual until the manual's next formal revision. The tool can be used to meet the QA requirements for the discipline and information gleaned can be used to plan future skills based training for front line staff. Its greatest value may be its use by front line staff in guiding them through a policy or environmental change process.

References:

Public Health Solutions Through Changes in Policies, Systems, and the Built Environment: Specialized Competencies for the Public Health Workforce, James Emory, MPH, and Carolyn Crump, PhD for the Directors of Health Promotion and Education, 2006.

Policy and Environmental Change: New Directions for Public Health Executive Summary, Association of State and Territorial Directors of Health Promotion and Public Health Education and US Centers for Disease Control, August 2001. *Note: ASTDHPPE has been renamed to DHPE*

Measuring the Competence of Healthcare Providers, Neeraj Kak, Bart Burkhalter, and Merri-Ann Cooper, Issue Paper of the Quality Assurance Project, July 2001 Volume No. 2 Issue 1.

Recommendations for Future Efforts in Community Health Promotion: Report of the National Expert Panel on Community Health Promotion, CDC, 2006.

Appendices:

QA Review Tool for Policy and Built Environmental Change Interventions: Description of Standards

QA Review Tool for Policy and Built Environmental Change Interventions (blank tool)

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QA Review Tool For Policy And Built Environment Change Interventions

Description of Standards

Met/Unmet/N/A: This rating applies to the total process and includes any efforts by policy change team members

Skill Level Definitions: This rating applies to the individual health educator being reviewed

N = Novice: No background or experience in the competency and need for guidance is high

A = Advanced Beginner: Demonstrates marginally acceptable performance and continued guidance is needed

C = Competent: Able to perform the competency with minimal guidance

P = Proficient: Able to perform with confidence and no guidance

E = Expert: Able to perform the competency with high proficiency and serve as a mentor for others

Updated 12/15/08

HPEC Competency* (Health Policy & Environmental Change)	met	unmet	N/A	Skill level	Standard
1. Analyze and Articulate the Problem					
1.1 Collects, summarizes and interprets information relevant to an issue					Uses a variety of data sources such as Census data, BRFSS, SCAN, literature review, etc to identify a problem. Level of data is appropriate to the intervention (e.g., county data for county ordinance).
1.2 Defines the problem as needing a policy, system, or environmental solution					Develops a clear and concise problem statement without predetermining a solution. "Snapshot" description is recommended.
2. Propose a Solution					
2.1 Defines criteria for selecting among proposed options to improve the problem					Determines priority criteria used to assess solution options. E.g., solution must be effective, affordable, and sustainable.
2.2 Records the options in clear and concise written statements.					Options are stated in a way understandable to stakeholders.
2.3 Estimates the health, fiscal, administrative, legal, social, and political implications of each option					Shows evidence that potential implications have been discussed and documented via reports or minutes.
2.4 Predicts the feasibility and expected outcome of each option					Assesses feasibility, effectiveness, benefits and harms, cost, acceptability, equitability, and sustainability for each option.
2.5 Analyzes the options using decision analysis methods (e.g., policy analysis matrix)					Uses some decision matrix or process to compare and analyze options such as a multi attribute table that rates multiple criteria for each solution or a four quadrant model of low cost/low impact, low cost/high impact, high cost/low impact, high cost/high impact.
2.6 Builds consensus for the chosen course of action					If facilitator, uses group process skills to foster cooperative decision making to reach consensus. If participant, promotes consideration of all viewpoints.
3. Influence the Change Process					
3.1 Plans an approach to change policies, systems, built environments					Develops a written action plan listing the action steps for strategies used to change policy. Plan includes task, person responsible, resources, and timeline.
3.2 Educates decision makers, media, partners, and the general public by providing relevant information					Uses multiple media, press releases, emails, and other communications to inform stakeholders of the need for the chosen action and its anticipated impact
3.3 Frames messages and tailors materials to influence the change process					Conducts focus groups, surveys, or interviews to develop messages that resonate with various audiences and are based on stages of change.

HPEC Competency* (Health Policy & Environmental Change)	met	unmet	N/A	Skill level	Standard
3.4 Implements policy-advocacy strategies					Provides written documentation of advocacy efforts via emails, meeting minutes, or briefing reports.
3.5 Implements communications strategies to impact social learning					Disseminates targeted messages developed from 3.2 through various media and community outlets such as faith, worksite, school, or local organizations.
3.6 Monitors the change process and its outcome					Communicates with key stakeholders to track support or opposition for the change effort and adjusts advocacy efforts based on feedback.
4. Monitor the Implementation Process					
4.1 Predicts how the relevant bureaucratic entities (eg, agencies) might implement the enacted changes					Researches the literature and seeks input from content experts to identify best practice related to the change.
4.2 Plans how to monitor and assist each entity as it develops the budgets, rules, guidelines, and procedures to implement the enacted change					Prepares a policy guidance packet relevant to the entity and the proposed change to include talking points, signage, relevant literature, etc.
4.3 Assists the entities with planning for structural and programmatic adjustments					Shares the policy guidance with the entity. Provides technical assistance to the entity to plan roll out of new policy/environmental change.
4.4 Monitors the implementation process to document how the solution is or is not functioning as intended					Develops a tracking system for implementation of action steps and interim impacts. Suggests changes in plan based on positive or negative impacts.
5. Evaluate the Impact					
5.1 Develops mechanisms to monitor policy/system/environmental change					Evaluation plan is integrated into the action steps of the implementation plan in 3.1.
5.2 Evaluates impact of the change					Assesses data pre and post intervention to evaluate impact. Includes unanticipated outcomes in evaluation.
5.3 Incorporates evaluation findings into future planning and analysis efforts					Shares evaluation findings with key stakeholders and uses the findings to improve future change efforts.
6. Strengths and Weaknesses					

* Taken from Public Health Solutions Through Changes in Policies, Systems, and the Built Environment: Specialized Competencies for the Public Health Workforce, James Emery, MPH, and Carolyn Crump, PhD for the Directors of Health Promotion and Education, 2006.

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QA Review Tool For Policy And Built Environment Change Interventions

Change intervention:

Date of review:

Staff responsible for intervention:

Reviewer:

Skill level definitions:

N = Novice: No background or experience in the competency and need for guidance is high

A = Advanced Beginner: Demonstrates marginally acceptable performance and continued guidance is needed

C = Competent: Able to perform the competency with minimal guidance

P = Proficient: Able to perform with confidence and no guidance

E = Expert: Able to perform the competency with high proficiency and serve as a mentor for others

Updated 9/5/08

HPEC Competency* (Health Policy & Environmental Change)	met	unmet	N/A	Skill level	Comments
1. Analyze and Articulate the Problem					
1.3 Collects, summarizes and interprets information relevant to an issue					
1.2 Defines the problem as needing a policy, system, or environmental solution					
2. Propose a Solution					
2.2 Defines criteria for selecting among proposed options to improve the problem					
2.2 Records the options in clear and concise written statements.					
2.3 Estimates the health, fiscal, administrative, legal, social, and political implications of each option					
2.4 Predicts the feasibility and expected outcome of each option					
2.5 Analyzes the options using decision analysis methods (eg, policy analysis matrix)					
2.6 Builds consensus for the chosen course of action					
3. Influence the Change Process					
3.2 Plans an approach to change policies, systems, built environments					
3.2 Educates decision makers, media, partners, and the general public by providing relevant information					
3.3 Frames messages and tailors materials to influence the change process					

HPEC Competency* <i>(Health Policy & Environmental Change)</i>	met	unmet	N/A	Skill level	Comments
3.7 Implements policy-advocacy strategies					
3.8 Implements communications strategies to impact social learning					
3.9 Monitors the change process and its outcome					
4. Monitor the Implementation Process					
4.1 Predicts how the relevant bureaucratic entities (eg, agencies) might implement the enacted changes					
4.2 Plans how to monitor and assist each entity as it develops the budgets, rules, guidelines, and procedures to implement the enacted change					
4.3 Assists the entities with planning for structural and programmatic adjustments					
4.4 Monitors the implementation process to document how the solution is or is not functioning as intended					
5. Evaluate the Impact					
5.2 Develops mechanisms to monitor policy/system/environmental change					
5.4 Evaluates impact of the change					
5.5 Incorporates evaluation findings into future planning and analysis efforts					
6. Strengths and Weaknesses					

* Taken from Public Health Solutions Through Changes in Policies, Systems, and the Built Environment: Specialized Competencies for the Public Health Workforce, James Emery, MPH, and Carolyn Crump, PhD for the Directors of Health Promotion and Education, 2006.